PROVIDENCE SPEECH AND HEARING CENTER

{Please Print} **PATIENT INFORMATION** (Información del Paciente, por favor imprenta)

Last Name (Apellido): _____ First Name (Nombre): _____

Address (Domicilio): _____ Apt. #: _____

City (Cuidad): _____ State (Estado): _____ Zip Code (Zona Postal): _____

Home Phone # (Nu. De Teléfono): _____ Work Phone # (Nu. De Teléfono Trabajo): _____

Cell phone # (Nu. Celular): _____ E-mail (Correo Electrónico): _____

Date of Birth (Fecha de Nacimiento): _____ Age (Edad): _____ Sex (Sexo): _____

Social Security # (Seguro Social): _____ Driver's License # (Un. Licencia de Conducir): _____

RESPONSIBLE PARTY (Persona Responsable)

Last Name (Apellido): _____ First Name (Nombre): _____

Address (Domicilio): _____ Apt. #: _____

City (Cuidad): _____ State (Estado): _____ Zip Code (Zona Postal) _____

Home Phone # (Nu. De Teléfono): _____ Work Phone # (Nu. De Teléfono Trabajo): _____

Cell phone # (Nu. Cellular): _____ E-mail (Correo Electrónico): _____

Date of Birth (Fecha de Nacimiento): _____ Age (Edad): _____ Sex (Sexo): _____

Social Security # (Seguro Social): _____ Driver's License # (Nu. Licencia de Conducir): _____

INSURANCE INFORMATION (Información de Seguro)

Insured Name (Nombre del Asegurado): _____ Date of Birth (Fecha de Nacimiento): _____

Insurance company name (Nombre de la aseguranza) _____ Policy (Póliza)/Group(Grupo)#: _____

Complete Insurance Address (Dirección completa de Seguros) _____

Subscriber # (Nu. Suscriptor): _____ Employer (Empleador): _____

Check one (Marque uno): ☐ HMO ☐ PPO ☐ EPO ☐ POS

Primary Care Physician (Doctor Primario):_____ Phone (Telefono):_____

Address (Domicilio):_____

SECONDARY INSURANCE (Información de Seguro Segundo)

Check one (Marque uno): ☐ Supplemental (Supplimental) or ☐ Retirement Plan (plan de jubilación)

Insured Name (Nombre del Asegurado): _____ Date of Birth (Fecha de Nacimiento): _____

Insurance company name (Nombre de la aseguranza) _____ Policy (Póliza)/Group(Grupo)#: _____

Complete Insurance Address (Dirección completa de Seguros) _____

Subscriber # (Nu Suscriptor): _____ Employer (Empleador): _____

Check one (Marque uno): ☐ HMO ☐ PPO ☐ EPO ☐ POS

Ethnicity, please check one (Etnicidad, por favor marque uno):

☐ Asian ☐ Black/African Amer. ☐ Amer. Indian/Alaska Native ☐ Latino/Hispanic ☐ Pacific Islander ☐ White/Caucasian
☐ Other _____

US Armed Services veteran status, check if applicable (EE.UU. Fuerzas Armadas condición de veteran, marque el que aplica):

☐ Patient/self (Paciente/si mismo) ☐ Patient's parent/guardian (Padre/s de paciente/guardian) ☐ Patient's spouse (Conyuge de paciente)

How did you hear about us? Please indicate from choices below (¿Cómo se entero acerca de nosotros? Por favor, indique las opciones de más abajo)

☐ Newspaper (periódico) ☐ Event (evento) ☐ Direct Mail (correo directo) ☐ Friend (amistad) ☐ Website (sitio web)
☐ Senior Center (centro de ancianos) ☐ Other (otro) _____

What is the name of the Physician that referred you? (¿Cual es el nombre del médico que lo refirió? _____

I hereby assign to Providence Speech and Hearing Center (PSHC) all monies to which I am entitled for charges related to the service(s) provided. I understand that I am financially responsible to PSHC for charges not covered by this assignment. Also, I authorize the release of any information in order to process claims. (El que firme, comprende que todos los cargos incurridos por mi o mis dependientes por servicios presentados son mi responsabilidad financiera. Todos los cargos de la corte, abogados o comisión necesaria para colectar esta cuenta serán agados por mí. Le doy permiso a esta agencia de comunicarse con mis empleadores. Al grado que sea necesario para determinar la responsabilidad de los pagos y obtener compensación, o autorizó la revelación de partes del expediente de este paciente.)

Signature (Firma): _____ Date (Fecha): _____

PROVIDENCE SPEECH AND HEARING CENTER

CONFIDENTIAL CHILD QUESTIONNAIRE
CUESTIONARIO CONFIDENCIAL DEL PACIENTE

I. General Information / Información general

Child's Name / Nombre Del Niño(a): _____

Birth date / Fecha de Nacimiento: _____

Legal Guardian's Name / Nombre del Tutor Legal: _____

Relationship to Child / Relación con el Niño (a): _____

Address / Dirección: _____

Street / Calle **City /** Ciudad **Zip code /** Código Postal

Home Phone # / Teléfono de Casa: _____ **Cell # /** Celular: _____

Child's Physician / Doctor del Niño(a): _____ **Phone # /** Número de Teléfono: _____

Address / Dirección: _____

Referred to center by / Referido al Centro por: _____ **For /** Para: _____

II. Background Information / Antecedentes

1. Describe the problem / Describa el problema: _____

2. When was the problem first noticed? By whom? / ¿Cuando fue notado el problema por primero vez? ¿Por quién? _____

3. Have there been any changes to your child's speech, language or hearing since that time? / ¿Han habido algunos cambios en el habla, lenguaje o audición del niño(a) desde ese momento? **Yes/**Sí ☐ **No** ☐

If yes, please explain / Si es así, por favor explique: _____

4. What language(s) are spoken in the home? / ¿Qué idioma se habla en casa? _____

5. Child's Primary Language and Parent's/Caregiver's Primary Language /Idioma principal del paciente y el de los padres o proveedor de cuidado _____

6. Where does your child spend most of their time? / ¿En donde pasa su hijo(a) la mayoría de su tiempo?

☐ **Home /** Casa ☐ **School /** Escuela ☐ **Other /** Otros _____

7. Child's siblings / Hermanos del niño (a): _____

8. All persons living in child's home / Todas las personas que vivan en casa con el niño(a):

9. During pregnancy, at birth, or immediately following birth, did mother or baby experience any unusual illness, condition, accident, or complications? / ¿Durante el embarazo, en el parto **Yes/**Sí ☐ **No** ☐

o inmediatamente después del nacimiento, pasaron la madre o el niño(a) por alguna enfermedad, condición rara o por algún accidente?
If yes, please explain/ Si es así, por favor explique: _____

_____

10. List any medications taken during pregnancy / Escriba los nombres de las medicinas que tomó durante el embarazo: _____

_____

11. What was length of pregnancy? / ¿Cuánto fue la duración del embarazo? _____

12. What was type of delivery? / ¿Cuál fue el tipo de parto? ☐ **Vaginal /** Vaginal ☐ **Cesarean /** Cesárea

☐ **Breech /** Parto de pies(al revés)

13. Birth weight? / ¿Cuánto peso al nacer? **Pounds /** Libras _____ **Ounces /** Onzas _____

14. At what age did your child do the following? / ¿A qué edad empezó su hijo(a) a hacer lo siguiente? :

Roll / Rodo _____ **Stand /** Se paro _____

Crawl / Gateo _____ **Walk /** Camino _____

Sit / Se sentó _____ **Feed him/herself /** Se alimento solo/a _____

Become toilet trained / Se entreno par ir al baño _____

Babble / Balbucear _____ **Speak first word /** Hablo su primera palabra _____

Combine two words / Combino dos palabras _____ **Use sentences /** utilizo oraciones _____

15. Has your child experienced any of the following? Please include age and severity. / ¿Ha experimentado su hijo(a) cualquiera de los siguientes? Por favor incluya la edad y la gravedad:

☐ **Feeding/swallowing/** Alimentación/para pasar comida

☐ **Cough, choke, throat-clear and/or gagging during eating or drinking /**Tos, ahogo/sofoco, atragantarse, carraspear con la garganta al comer o tomar _____

☐ **Wet, gurgly sounding voice or breath during eating /** Voz sofocada o respiracion agitada al comer _____

☐ **Chicken Pox** /Varicela ☐ **Measles**/ Sarampión _____

☐ **Pneumonia** / Neumonía _____

☐ **Tonsillectomy**/ Amigdalotomía _____

☐ **Influenza/** Influenza _____

☐ **Allergies**/ Alegáis _____

☐ **Headaches/** Dolores de Cabeza _____

☐ **Sinus/** Sinus Nasal _____

☐ **Epilepsy**/ Epilepsia _____

☐ **Meningitis/** Meningitis _____

☐ **Encephalitis**/ Encefalitis _____

☐ **Dental Problems**/Problemas Dentales _____

☐ **Ear Infections/** Infecciones de Oído _____

☐ **Tonsillitis**/ Amigdalitis _____

☐ **Draining Ears**/ Flujo en los Oídos _____

☐ **Chronic Colds**/Resfriados Crónicos

☐ **Head Injuries**/Lesiones en la Cabeza

☐ **Asthma**/Asma

☐ **Other Illnesses or Surgeries** /Otras Enfermedades o Cirugías

☐ **P.E. Tubes Insertion/** Inserción de Tubos

☐ **Adenoidectomy/** Adenoidectonomía

☐ **Convulsions /** Convulsiones

☐ **Surgeries /** Cirugías

16. Have any of the following conditions affected members of your immediate family? (check all that apply) / ¿Han afectado alguna de las siguientes condiciones a algún miembro inmediato de la familia? (marque todas las que apliquen):

☐ **Deafness**/Sordera

☐ **Diseases/**Enfermedades

☐ **Stuttering**/Tartamudeo

☐ **Delayed Motor Skills/**Retraso en las Habilidades Motoras

☐ **Neurologic**/Neurológica

☐ **Delayed Speech/** Retraso en el Habla

☐ **Cleft Lip & Palate**/ Paladar y labio hendido

☐ **Other**/Otras:

17. Is your child presently taking any medication? / ¿Actualmente está tomando su hijo (a) algún medicamento? **Yes/**Sí ☐ **No** ☐

If yes, please include name and purpose / Si es así, por favor incluya el nombre y propósito:

18. Does your child have any allergies? / ¿Tiene su hijo(a) algún tipo de alergia? **Yes/**Sí ☐ **No** ☐

If yes, please explain / Si es así, por favor explique:

19. Does your child have any medical diagnosis? (ex. Autism Spectrum Disorder, ADHD, Down Syndrome) / ¿Su hijo(a) ha recibido algún diagnostico médico? (por ejemplo, Trastorno del espectro autista, ADHD, Síndrome de down) **Yes/**Sí ☐ **No** ☐

If yes, please explain / Si es así, por favor explique:

A. Therapeutic History/ Historial Terapéutico

1. Has your child ever been evaluated by a / ¿ Alguna vez su hijo(a) ha sido evaluado por un:

a. **Neurologist, psychologist or other medical specialist? /** ¿Neurólogo, Psicólogo o algún otro especialista médico? **Yes/**Sí ☐ **No** ☐

If yes, please include place, date and results. / Si es así, por favor incluya lugar, fecha y resultados:

b. **Audiologist (for hearing test)? /** ¿Audiólogo (para un examen de audición)? **Yes/**Sí ☐ **No** ☐

If yes, please include place, date and results. / Si es así, por favor incluya lugar, fecha y resultados:

c. **Ear Nose or Throat Doctor? /** ¿Especialista de oídos, nariz y garganta? **Yes/**Sí ☐ **No** ☐

If yes, please include place, date and results. / Si es así, por favor incluya lugar, fecha y resultados:

---

d. Opthamologist (for visión test)?/ ¿Oftalmólogo (para un examen de la vista)? **Yes/**Sí ☐ **No** ☐

If yes, please include place, date and results. / Si es así, por favor incluya lugar, fecha y resultados:

---

e. Physical or Occupational Therapist? / ¿Terapeuta físico u ocupacional? **Yes/**Sí ☐ **No** ☐

If yes, please include place, date and results. / Si es así, por favor incluya lugar, fecha y resultados:

---

f. Speech-Language Pathologist? / ¿Patólogo del haba y lenguaje? **Yes/**Sí ☐ **No** ☐

If yes, please include place, date and results. / Si es así, por favor incluya lugar, fecha y resultados:

---

2. Does your child receive any other services? Or previous intervention? (e.g. speech/language therapy, occupational/physical therapy, behavior therapy, etc.) / ¿Recibe su hijo(a) otros servicios? O ¿ha tenido intervenciones previas? (por ejemplo. Terapia del habla/lenguaje, terapia ocupacional/física, terapia de comportamiento, etc. **Yes/**Sí ☐ **No** ☐

If yes, please explain and include dates of services / Si es así, por favor explique e incluya las fechas de los servicios.

B. Speech, Language, and Hearing History
Historia del Habla, Lenguaje, y Audición

1. Which of the following does this child use to communicate? / ¿Cuál de lo siguiente usa el menor para comunicarse?

☐ **Gestures /** Gestos ☐ **Sounds /** Sonidos ☐ **One- word /** Una-palabra

☐ **Phrases /** Frases ☐ **Sentences /** Oraciones ☐ **Sign Language /** Lenguaje de signos

☐ **Augmentative Communicative Device (AAC) /** Dispositivo de comunicación aumentativa

2. How well can he/she be understood by parents (e.g. 80% of the time) ? / ¿Qué tan bien puede ser él/ella entendido(a) por los padres (por ejemplo, 80% de las veces)?:

3. By other family (e.g. 80% of the time)? / ¿Por otros familiares (por ejemplo, 80% de las veces)?

4. By unfamiliar people (e.g. 80% of the time)? / ¿Por personas desconocidas (por ejemplo, 80% de las veces)?

5. How many words are in the child's vocabulary? / ¿Cuántas palabras hay en el vocabulario de su hijo(a)?

6. Do you have concerns with: / Tiene alguna preocupación con:

a. How your child expresses him/herself? / ¿Cómo se expresa su hijo (a)? **Yes/**Sí ☐ **No** ☐

If yes, explain / Si es así, explique.

b. **Your childs ability to understand directions? /** ¿La habilidad de su hijo(a) para entender indicaciones? **Yes/**Sí ☐ **No** ☐

If yes, explain / Si es así, explique.

c. **How your child's voice sounds? (e.g. Hoarse or high pitch voice, or nasal)/** ¿ Cómo suena la voz de su hijo (a)? (Por ejemplo, ronca o voz aguda (tono alto) o nasal) **Yes/**Sí ☐ **No** ☐

If yes, explain / Si es así, explique.

d. **Your child's fluency (e.g. stutters, repeats parts of words)? /** ¿La fluidez de su hijo(a) (por ejemplo, tartamudea, repite partes de las palabras)? **Yes/**Sí ☐ **No** ☐

If yes, explain / Si es así, explique.

C. Social/Behavioral/Educational History

Historial Social/Educacional y de Comportamiento

1. Describe your child's personality / Describa la personalidad de su hijo(a).

2. How does your child prefer to play, alone or with other children? / ¿Cómo prefiere jugar su hijo(a), solo o con otros niños?

3. Does your child have temper tantrums? / ¿Tiene su hijo rabietas prolongadas (berrinches)? **Yes/**Sí ☐ **No** ☐

4. Does your child play with toys/objects in an unusual manner? / ¿Juega su hijo con juguetes/objetos de una manera inusual? **Yes/**Sí ☐ **No** ☐

5. Does your child get along with other children? / **¿**Se lleva bien su hijo con otros niños? **Yes/**Sí ☐ **No** ☐

6. Does your child have difficulty attending to activities? / ¿Tiene su hijo dificultad para poner atención a las actividades? **Yes/**Sí ☐ **No** ☐

7. Does your child have difficulty tolerating transitions or unexpected changes to his/her routine? / ¿Tiene su hijo dificultad para transiciones o cambios inesperados en su rutina? **Yes/**Sí ☐ **No** ☐

8. Is there anything about your child's behavior that concerns you? / ¿Hay algo en el comportamiento de su hijo(a) que le preocupe? **Yes/**Sí ☐ **No** ☐

If yes, please explain/ Si es así, por favor explique:

10. Please fill out the following if your child attends school (including preschool) / Por favor, complete lo siguiente, si su hijo(a) asiste la escuela (incluyendo el prescolar):

Present School / Escuela Actual: **Phone # /** Teléfono:

Address / Dirección:

Teacher /Maestro(a): **Grade /** Grado:

Has your child's teacher noted any speech/language problems? / ¿Ha notado el maestro (a) algunos problemas del habla o lenguaje de su hijo (a)? **Yes/**Sí ☐ **No** ☐

If yes, please explain / Si es así, por favor explique:

D. Occupational/Developmental/Adaptive Development

Desarrollo de Adaptación /Ocupacional y Desarollo

1. Do you have any concerns regarding your childs fine motor skills, sensory processing, dressing skills, or feeding?/ ¿Tiene algúna preocupación en cuanto a las habilidades motoras finas de su hijo, del procesamiento sensorial, habilidades para vestirse o para alimentarse? **Yes/**Sí ☐ **No** ☐

If yes, please explain / Si es así, por favor explique:

Sensory Processing / Procedimiento Sensorial

2. Check all that apply / Marque todas las que apliquen:

☐ **Avoids certain foods /** Evita ciertas comidas

☐ **Enjoys playground play (swings, slides) /** Disfruta jugar afuera (columpios, tobogán)

☐ **Avoids having feet off ground /** Evita tener los pies fuera del suelo

☐ **Prefers activities that are less active /** Prefiere actividades que son menos activas

☐ **Walks on toes /** Camina sobre los dedos de los pies

☐ **Seeks out hugs/touch /** Busca abrazos/ ser tocado

☐ **Resists being touched/hugged /** Resiste ser tocado/ abrazado

☐ **Seems clumsy, uncoordinated or falls easily /** Se mira torpe, descoordinado o se cae fácilmente

☐ **Avoids or is upset by being messy /** Evita estar sucio/a o se enoja cuando se ensucia

☐ **Gets upset by certain noises /** Se molesta con ciertos ruidos

E. Physical Therapy/Motor Skills

Terapia Física/Habilidades Motoras

1. **Describe the way your child moves around** /Describa la forma en que su hijo(a) se mueve:
   ☐ **Rolls/**Rodar ☐ **Crawl/**Gatear ☐ **Pulls to stand/**Detener para parar ☐ **Stand/Cruises**/Parar ☐ **Walk/**Caminar

2. **Does your child appear/** Aparenta ser su hijo(a):
   ☐ **Clumsy/**Torpe ☐ **Awkward/**Raro ☐ **Stiff/**Tieso ☐ **Weak/**Debil

3. **Does your child fall often?** / ¿ Su hijo(a) se cae frecuentemente? ☐ **Yes/**Si ☐ **No**

4. **Are you concerned about your child's safety while moving?/** ¿Tiene preocupación de la seguridad de su hijo(a) cuando se mueve? ☐ **Yes/**Si ☐ **No**

5. **Does your child appear to have difficulties keeping up with peers?/**Su hijo(a) aparenta tener dificultad manteniéndose con sus compañeros (caminando, corriendo, movimientos físicos) ☐ **Yes/**Si ☐ **No**
   If yes, please explain / Si es así, por favor explique**:** _____
   _____

6. **Does your child walk on his/her toes for long periods of time?/** ¿Su hijo(a) camina sobre los dedos de los pies por mucho tiempo? ☐ **Yes/**Si ☐ **No**

PROVIDENCE SPEECH AND HEARING CENTER

CONSENT TO RELEASE MEDICAL/EDUCATIONAL HISTORY

CONSENTIMIENTO PARA CEDER HISTORIAL MÉDICA Y EDUCACIONAL

Patient Name/Nombre del Paciente	**Date of Birth/**Fecha de Nacimiento
City/Cuidad	**State/**Estado
Date/Fecha	

To Whom It May Concern *(A Quién Corresponda)*:

This authorizes all physicians, hospitals, medical attendants, school districts personnel (E.G., SLP, Psychologists, Teachers) to furnish any and all medical records, educational records, history and information to Providence Speech and Hearing Center, or to any representative of Providence Speech and Hearing Center, concerning my medical condition. This authorization also includes examination of all hospital records, x-ray film, IEP documents, audio evaluations or screenings, prior evaluations, OT or PT report and furnishing of any information including opinions. You are further requested not to disclose such information to any other person without written authority to do so. *(Esto autoriza a todos los médicos, hospitales, asistentes-medico, personal del distrito escolar (EG, SLP, Psicólogos, Maestros) a proporcionar cualquier y todos los expedientes médicos, expedientes educacionales, historial y la información a el Centro Providence del Habla y Audiencia, o a cualquier representante del Centro Providence del Habla y Audiencia en relación con mi condición médica. Esta autorización también incluye la exanimación de todos los expedientes del hospital, de rayos X, documentos de IEP, evaluaciones de audio o detecciones, evaluaciones previas, reportes de OT o PT y el suministro de cualquier información, incluyendo opiniones. Le pedimos además no revelar esta información a cualquier otra persona sin autorización escrita para hacerlo).*

All prior authorization is hereby cancelled. *(Toda autorización previa queda cancelada).*

Patient / Parent / Legal Guardian
Paciente / Padre de familia / Tutor legal

Revised 9/20/13

PROVIDENCE SPEECH AND HEARING CENTER

Who do you authorize to receive copies of records? Please complete one section for each physician, facility, or for yourself. (A quien le autoriza que reciba copias de registros médicos? Por favor complete una sección para cada médico, facilidad, o para usted mismo.)

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to (Yo, el abajo firmante, le autorizo a Providence Speech and Hearing Center proveer información o documentación medica a):

Facility or Physician (Instalación o el médico): ______________________ Phone # (Nu. de Teléfono): ________________

Address (Dirección): ____ Ste: ____________________

City (Cuidad): __________________________ State (Estado): ______________ Zip Code (Código postal): _________

Signature of representative to patient (Firma del representante del paciente): ______________________________________

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to (Yo, el abajo firmante, le autorizo a Providence Speech and Hearing Center proveer información o documentación medica a):

Facility or Physician (Instalación o el médico): ______________________ Phone # (Nu. de Teléfono): ________________

Address (Dirección): ____ Ste: ____________________

City (Cuidad): __________________________ State (Estado): ______________ Zip Code (Código postal): _________

Signature of representative to patient (Firma del representante del paciente): ______________________________________

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to (Yo, el abajo firmante, le autorizo a Providence Speech and Hearing Center proveer información o documentación medica a):

Facility or Physician (Instalación o el médico): ______________________ Phone # (Nu. de Teléfono): ________________

Address (Dirección): ____ Ste: ____________________

City (Cuidad): __________________________ State (Estado): ______________ Zip Code (Código postal): _________

Signature of representative to patient (Firma del representante del paciente): ______________________________________

I, the undersigned, hereby authorize Providence Speech and Hearing Center to provide medical information or records to (Yo, el abajo firmante, le autorizo a Providence Speech and Hearing Center proveer información o documentación medica a):

Facility or Physician (Instalación o el médico): ______________________ Phone # (Nu. de Teléfono): ________________

Address (Dirección): ____ Ste: ____________________

City (Cuidad): __________________________ State (Estado): ______________ Zip Code (Código postal): _________

Signature of representative to patient (Firma del representante del paciente): ______________________________________

Revised 9/20/13

PROVIDENCE SPEECH AND HEARING CENTER

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Summary

By law, we are required to provide you with our **Notice of Privacy Practices** (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

Use and Disclosure of your Health Information:

1. To comply with requests from public health authorities and health oversight agencies which are required by law to collect health information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
5. If you are a member of U.S. or foreign military forces, including veterans, and if required by the appropriate authorities.
6. To federal government officials for intelligence and national security activities required by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers' Compensation and similar programs.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. We are required by law to maintain the confidentiality of your health information as prescribed by HIPAA. These HIPAA guidelines are summarized above for your information and understanding. A full copy of the Center's privacy policies is available for review upon request.

If you have any questions about this Notice of Privacy Practices or Providence Speech and Hearing Center's health information privacy policies, please contact Robyn Belz at the phone number listed below.

Effective Date of this Notice: _____(write date you received this notice)

Contact Person: Privacy Officer, C/O Providence Speech and Hearing Center
1301 Providence Avenue, Orange CA 92868
Phone Number: (714) 639-4990

Acknowledgement of Notice of Privacy Practices

"I hereby acknowledge that I have received a copy of the Center's Notice of Privacy Practices. I understand that if I have questions or complaints regarding my privacy rights that I may contact the person listed above. I further understand that the practice will offer me any updates to this Notice of Privacy Practices should it be amended, modified, or changed in any way."

Patient Name (please print) _____

Patient or Representative Signature_____ Date _____

Patient refused to sign _____

Patient was unable to sign because _____

PSHC Representative Name _____

Revised 8/7/2014

PROVIDENCE SPEECH AND HEARING CENTER

HIPAA AUTHORIZATION TO USE HEALTH INFORMATION FOR FUNDRAISING AND MARKETING ACTIVITIES

Purpose of this Form:
A federal law known as the Health Insurance Portability and Accountability Act (HIPAA) protects how your health information is used. HIPAA does not allow your health information to be used or released for certain purposes without your written permission. State laws also protect how your health information may be used.

Providence Speech and Hearing Center ("Providence") is dedicated to providing high quality patient care. As a nonprofit organization, Providence relies on the generosity of donations from patients and others to continue to fulfill its clinical care mission. Providence periodically contacts patients and others to inform them of new programs, services and initiatives that may be of interest or are supported by our fundraising efforts.

By signing this form, you are allowing your health care providers (for example, speech language pathologist, audiologist) to release your health information for the marketing and fundraising efforts described in this form. You will be given a signed copy of this authorization.

How Your Health Information Will Be Used:
This authorization permits Providence clinical staff and marketing and fundraising personnel to use your contact and other demographic information and the name(s) of your Providence treating physicians and information about your health care, to identify programs and initiatives that are likely to interest you, such as programs relating to your care and treatment, and to contact you about them for fundraising purposes and to include you on mailing lists. Providence will not provide this information to unrelated parties for their own marketing and fundraising.

How long will this authorization be in effect?
This authorization will remain in effect for ten (10) years from the date of signature. Once your authorization expires, we may need your signature again.

What if I don't want to sign, or later change my mind?
Signing this form is entirely voluntary. If you don't sign, this will not affect Providence's clinical treatment of you, or your eligibility for benefits. If you change your mind at any time, you can revoke (cancel) this authorization by providing a written notice of revocation to Providence Speech and Hearing Center, 1301 W. Providence Avenue, Orange, CA 92868, stating that you are revoking your authorization regarding fundraising and/or marketing. It will be effective upon receipt.

Are the individuals who receive my health information pursuant to this authorization permitted to use or disclose it for other purposes?
No. Providence policies and California law prohibit anyone who receives your health information pursuant to this authorization from using or releasing it for other purposes except with your written authorization or as specifically required or permitted by law. Federal privacy protections are narrower and may not apply to everyone who receives your health information, but California law would still apply.

I have read and understand the terms of this authorization and I have had an opportunity to ask questions about Providence's use of my health information described in this form. I hereby knowingly and voluntarily authorize Providence to use such information for the purposes described above.

_____ _____
Signature of Individual Date

If Individual is unable to sign this Authorization, please complete below:

_____ _____
Signature of Legal Guardian/Legal Relationship/ Personal Representative Date

PROVIDENCE SPEECH AND HEARING CENTER

FINANCIAL POLICY
STATEMENT OF FINANCIAL RESPONSIBILITY

Thank you for using Providence Speech and Hearing Center as your health care provider.

We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is statement of our Financial Policy, which we require you to read and sign prior to any treatment. All patients must read and sign this policy before being seen.

ALL COPAY AND DEDUCTIBLE MONIES ARE DUE AT TIME OF SERVICE
WE ACCEPT CASH, CHECKS, VISA/MASTERCARD AND AMERICAN EXPRESS

REGARDING PAYMENT: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All charged incurred are the responsibility of the patient or their guarantor. We will bill your insurance company as a courtesy. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. If your insurance company has not paid your account within 60 days, the balance will automatically be billed to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and /or other medical insurance. Benefit inquiries and authorizations are not a guarantee of payment by your insurance company.

OVERPAYMENT: Our policy is to collect a payment of 50% of charges at the time of service for non-provider insured patients, unless other arrangements have been made. If you feel you have overpaid, please contact our Billing Department so we can research and process any refunds due to you. All refunds are processed in the same manner as payment was received. If any credits on your account are due to insurance overpayments, a refund will be made to the insurance company.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our geographic area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Prearranged contracts will be honored.

MINOR PATIENTS: The adults accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, treatment will be denied unless charges have been pre-authorized to an approved credit plan, such as a Visa, MasterCard, or American Express, or paid by cash or check at time of service.

MISSED APPOINTMENTS: Unless canceled 24 hours in advance, our policy is to charge for missed appointments at the rate of the missed session. Please help us serve you better by keeping scheduled appointments.

INTEREST: We reserve the right to charge interest in the amount of 10% as provided by state law.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Patient's Name (printed)	Signature of Patient or Responsible Party
Date	

Revised 8/7/14